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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 21 1992

The Honorable Dan Quayle
President of the Senate
Washington, D.C. 20510

9/23/13

Dear Mr. President:

I am respectfully submitting our Calendar Year (CY) 1993 Medicare physician fee schedule update and Fiscal Year (FY) 1993 Medicare volume performance standards (MVPS) recommendations, and our CY 1992 report on monitoring utilization of and access to services for Medicare beneficiaries. Section 1848 of the Social Security Act (the Act) requires the Secretary of Health and Human Services (1) to report on the rates of increase of Medicare expenditures for physician services compared with the performance standard rates of increase, (2) to recommend annual updates to the Medicare physician fee schedule and MVPS rates of increase, and (3) to report on changes in utilization and access to services.

Pursuant to section 1848 of the Act, we are recommending physician fee schedule updates of 2.6 percent for surgical services and 0.3 percent for nonsurgical services. Separate updates will be applied on a procedure specific basis and will not lead to payment differentials based on physician specialty. Our recommended updates essentially follow the default methodology which would be used to determine the updates in the event they are not set by Congress. That is, we are recommending that the updates equal the Medicare Economic Index plus or minus the number of percentage points that the increase in expenditures exceeded or was less than the performance standard rate of increase for surgical and nonsurgical services for FY 1991.

We are recommending performance standard rates of increase of 6.0 percent for surgical services and 7.9 percent for other services. These performance standards were determined by combining the effects of inflation, increasing enrollment and aging of Medicare beneficiaries, and other factors such as the effect of legislative factors and implementation of the physician fee schedule.

For FY 1993, we are recommending separate performance standards for surgical and other services, consistent with the structure of present law. However, the Department is presently considering a single performance standard and single update for FY 1994 and subsequent years. A single update could help ensure that the fee schedule fulfills its promise to shift payments from procedure oriented services to primary care and other medical visits.

Further, because of my deep concern about the need for incentives to provide primary care and to stimulate greater supply of primary care practitioners, I am considering a number of additional options, both legislative and administrative, that might help achieve this goal. Among those approaches under study are the following:

(1) Accelerating the fee schedule transition. This would give primary care physicians the gains they anticipate under the fee schedule more rapidly than under present law. A budget neutral implementation would also make more abrupt the decreases in payments for many procedural services.

(2) Modification of the MVPS. While I am giving serious consideration to a single MVPS for FY 1994 and subsequent years, it might also be prudent to consider establishing a separate and higher performance standard for primary care services.

(3) Emphasizing primary care training through Medicare graduate medical education (GME) payments. This could involve a basic restructuring of GME payments to favor primary care and redirect GME payments to non-hospital based ambulatory residency training sites.

(4) Strengthening the Focus on Primary Care in Public Health Service (PHS) programs. This could place increased emphasis on primary care in PHS educational assistance and other programs.

I want to emphasize a set of policies to revitalize primary care, representing either new departures or renewed emphases. It is very important to me to obtain input from physicians, the Congress and others on the key elements of such a package.

We are also submitting the report entitled "Monitoring Utilization of and Access to Services for Medicare Beneficiaries Under Physician Payment Reform." This report describes methods to examine use of and access to physicians' services by Medicare beneficiaries under payment reform: (1) the development of a monitoring system to provide information on use of Part B services and on physician availability under payment reform, and (2) the development of baseline data for the period before payment reform.

Sincerely,

Louis W. Sullivan

Louis W. Sullivan, M.D.

Enclosures (3)

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 21 1992

The Honorable Thomas S. Foley
Speaker of the House of Representatives
Washington D.C. 20515

Dear Mr. Speaker:

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Sincerely,

Louis W. Sullivan

Louis W. Sullivan, M.D.

Enclosures (3)

Physician Fee Schedule Update Recommendation For Calendar Year 1993

Background

The Omnibus Budget Reconciliation Act (OBRA) of 1989 added section 1848 to the Social Security Act (the Act). Section 1848 of the Act provides for a comprehensive package of Medicare physician payment reform that included the following provisions:

- The reasonable charge payment mechanism which based payment on physicians' charges was replaced by a physician fee schedule beginning January 1, 1992.

- Performance standard rates of increase are established to control the rate of growth of expenditures for physicians' services.

Under the physician fee schedule, payment for a service equals the product of the relative value unit for a service, a geographic adjustment factor, and a conversion factor. Relative value units measure the relative amount of resources used by physicians to provide different services while the geographic adjustment factor measures practice costs differences between areas. The conversion factor converts relative value units to dollar amounts.

Under section 1848(d)(2) of the Act, the Secretary annually recommends a fee schedule update to Congress by April 15. The Physician Payment Review Commission (PPRC) reviews the Secretary's recommendation and makes its own recommendation by May 15. If Congress does not set an update by October 31, the update will be established through an automatic default mechanism as set forth in section 1848(d)(3) of the Act. Under this mechanism, the update will equal the Medicare Economic Index (MEI) increased or decreased by the number of percentage points by which actual expenditures in the second preceding fiscal year exceeded or were less than the performance standard rate of increase established for that year. The adjustment to the MEI for a category of physicians' services cannot be reduced by more than 2 percentage points in 1993, 2.5 percentage points in 1994 and 1995, and 3 percentage points in any succeeding year. There is no limit on upward adjustments to the MEI.

Section 1848(a)(2) provides for a transition from the reasonable charge payment system to the physician fee schedule for some services. For services subject to the transition rules, payment in 1993 will equal 75 percent of the payment in 1992 (which was a blend of the average payment in a locality under the reasonable charge payment system and the physician fee schedule) and conversion factor. Consequently, we will refer to both updates

(the conversion factor and the 1992 payment amount) as the update in the physician fee schedule.

Statutory Requirement

Pursuant to section 1848(d) of the Act, the Secretary shall provide Congress with his recommendation of a fee schedule update by April 15th of each year. The Secretary is required to consider the following factors:

- The percentage change in the MEI (a measure of the increase in the cost of operating a medical practice);
- The percentage by which actual expenditures for physicians' services in the first preceding fiscal year were less than or exceeded actual expenditures in the second preceding fiscal year;
- The relationship between the percentage determined above for a fiscal year and the performance standard rate of increase for that fiscal year (this factor is to be adjusted to account for changes in the proportion of Medicare beneficiaries enrolling in health maintenance organizations (HMOs));
- Changes in the volume and intensity of services;
- Access to services; and
- Other factors that may contribute to changes in volume and intensity of services or access to services.

The Secretary also may consider:

- Unexpected changes by physicians in response to implementation of the fee schedule;
- Unexpected changes in outlay projections;
- Changes in the quality or appropriateness of care; and
- Any other relevant factors not measured in the resource-based payment methodology.

Pursuant to section 1848(d)(2)(D), the Secretary's report to Congress must include the following:

- The update recommended for each category of physicians' services and for the following groups of physicians'services: nonsurgical services, visits, consultations and emergency room services;

- The rationale for the recommended update for each category and group of services described above; and

- The data and analyses underlying the recommended update(s).

Section 1848(d)(2)(E) of the Act requires the Secretary to provide a statement of the percentage by which actual expenditures were less than or exceeded projected expenditures for the first preceding fiscal year. Projected expenditures are actual expenditures in the second preceding fiscal year increased by the following factors:

- The weighted average percentage increase in payments for physicians services for the preceding fiscal year;

- The percentage increase in the number of non-HMO Part B enrollees;

- The average annual growth in the volume and intensity of services for the preceding 5-year period ending with the second preceding fiscal year; and

- The percentage change in expenditures resulting from changes in law or regulations.

Our best projection of the baseline rate of increase for FY 1991 (after considering the effect of provisions included in OBRA 1990) was 8.4 percent. (Using the statutory formula specified above results in an 8.5 percent increase for FY 1991.) The FY 1991 MVPS was 7.3 percent for all physician services (3.3 percent for surgical services and 8.6 percent for nonsurgical services). The difference between our projection and the MVPS enacted for FY 1991 is due to two factors: (1) the MVPS reduces the expenditure projection by a performance standard factor of two percentage points, and (2) the 1991 MVPS was calculated using an additive formula provided in the law while our projections are based on a multiplicative formula. As discussed below, we are recommending that the 1993 update be based on a comparison of actual expenditures with the published FY 1991 MVPS. However, as we have noted, section 1848(d)(2)(E) of the Act requires that we compare projected and actual expenditures.

We estimate that actual expenditures between FY 1990 and FY 1991 increased by 8.6 percent for all physician services or 0.2 percentage points more than our projection (0.1 percentage points more than the projection using the section 1848(d)(2)(E) methodology). We would point out that our projection of 8.4 percent for FY 1991 included a baseline adjustment for volume and intensity of services to account for payment reductions

legislated by OBRA 1990. Our overall projection would have been about 5.6 percentage points lower had we not included this baseline adjustment. As the actual rate of increase in expenditures was only 0.2 percentage points more than our projection, we think this demonstrates that use of a baseline adjustment yields a better projection of the increase in Medicare outlays for physician services than not using one.

1993 Physician Fee Schedule Update

The following sections discuss the factors considered in the development of the CY 1993 physician fee schedule update.

The Percentage Change in the MEI

The MEI is a measure of inflation in selected factors that are most relevant to physicians in office practice. The office expense component comprises such factors as employee wages, rents, transportation, drugs and medical supplies, malpractice insurance and other miscellaneous expenses and has a weight of 40 percent. The physicians's own time or earnings component comprises increases in earnings less increases in productivity of nonfarm workers and has a weight of 60 percent. Annual increases in these factors are measured to arrive at the MEI. Our most recent estimate of the MEI for CY 1993 is 2.2 percent. However, our current MEI estimate could change between now and when the CY 1993 physician fee schedule update is determined because of more recent economic data and use of a new methodology for computing the MEI which will finalize a proposed policy published in the Federal Register on September 9, 1991.

Percentage Growth in Actual Expenditures

Section 1848(d)(2)(A)(ii) of the Act requires the Secretary to consider the percentage growth in actual expenditures from the second preceding fiscal year to the first preceding fiscal year for physicians' services. (We have defined physicians' services for the purposes of the fee schedule update and performance standard rates of increase in our notices of the FY 1990, FY 1991 and FY 1992 performance standard rates of increase published in the Federal Register on December 29, 1989 [54 FR 53818], December 28, 1990 [55 FR 53356] and November 25, 1991 [56 FR 59813].)

Our estimate of the percentage growth in physicians' services between the second preceding fiscal year, FY 1990, and the first preceding fiscal year, FY 1991, is 8.6 percent for all physician services, 2.9 percent for surgical services and 10.5 percent for non-surgical services.

Performance Relative to the MVPS

Performance relative to the MVPS is illustrated in the table below:

Actual Performance vs. FY 1991 MVPS

	All Services	Surgery	Non-Surgery
(1) FY 1991 MVPS	7.3%	3.3%	8.6%
(2) Actual Performance	8.6%	2.9%	10.5%
(3) Difference	+1.3%	-0.4%	+1.9%

Section 1848(f)(3) of the Act requires the Secretary to monitor compliance with the performance standard and provide reports to Congress. This report of the percentage increase in expenditures between FY 1990 and FY 1991 addresses this requirement for FY 1991. Because of improvements in our data systems, we expect to submit more timely reports monitoring compliance with the performance standard beginning with FY 1992. We expect to submit our first FY 1992 report shortly.

Changes in Volume and Intensity

The FY 1991 performance standard included an allowance for this factor. We do not have any evidence that the update should be further adjusted to account for this factor.

Access to Services

Our report, "Monitoring Utilization and Access to Services for Medicare Beneficiaries," discusses our efforts and future plans to monitor utilization and access. In summary, we do not have any evidence of a national problem of access to care for Medicare patients nor have we seen any evidence of substantial problems at any local level. Furthermore, we would note that participation and assignment rates in recent years have continually increased and are now at an all time high. Thus, we do not believe the update factor should be increased for this factor. However, we will continue to monitor access which will include obtaining data from the Current Beneficiary Survey (an ongoing survey of current Medicare beneficiaries) to assist us and the Congress with future fee schedule updates.

Unexpected Changes by Physicians in Response to Fee Schedule Implementation and Unexpected Changes in Outlay Projections

Implementation of the fee schedule on January 1, 1992, is a major change in the way physicians are paid for providing Medicare services. While payments for individual services are increasing or decreasing with this change, we do not currently have data to evaluate responses to fee schedule implementation.

Changes in the Quality or Appropriateness of Care

As we explained in our update recommendation for CY 1992 and this year's MVPS recommendation, we are concerned about inappropriate utilization of specific procedures and administrative practices such as unbundling and upcoding which have the effect of increasing expenditures for Medicare services. However, we do not expect studies of inappropriate utilization to yield precise results which will allow us to account for this factor in either our recommendations of a fee schedule update or the performance standard rates of increase. We will continue to study the extent of inappropriate utilization and aberrant billing practices. While these efforts may not be useful for the update and MVPS recommendations, we expect our studies will provide useful insights regarding inappropriate utilization and will ultimately lead to improvements in the practice of medicine.

Update Recommendation for CY 1993

In developing our update recommendation for CY 1993, we struggled to balance three competing principles. First, we want to ensure that the fee schedule fulfills its promise to shift payments from procedure oriented services to primary care and other medical visits. Second, we want to demonstrate our commitment to the MVPS process by honoring the implicit "contract" with physicians to adjust the 1993 update by actual performance against the published standards. Third, it is important to acknowledge that there is a crisis in the supply of primary care practitioners that must be addressed.

Having considered these three goals, we decided to make a recommendation for FY 1993 consistent with the structure of present law, which calls for separate treatment of surgical and nonsurgical services. However, for FY 1994 and subsequent years we are considering a single MVPS approach.

In addition, because of my deep concern about the need for incentives to provide primary care and to stimulate greater supply of primary care practitioners, we are considering a number of additional options, both legislative and administrative, that might help achieve this goal. Among those approaches under study are the following:

(1) Accelerating the fee schedule transition. This would give primary care physicians the gains they anticipate under the fee schedule more rapidly than under present law. A budget neutral implementation would also make more abrupt the decreases in payments for many procedural services.

(2) Modification of the MVPS. While I am giving serious consideration to a single MVPS for FY 1994 and subsequent years, it might also be prudent to consider establishing a separate and higher performance standard for primary care services.

(3) Emphasizing primary care training through Medicare graduate medical education (GME) payments. This could involve a basic restructuring of GME payments to favor primary care and redirect GME payments to non-hospital based ambulatory residency training sites.

(4) Strengthening the Focus on Primary Care in Public Health Service (PHS) programs. This could place increased emphasis on primary care in PHS educational assistance and other programs.

We want to emphasize a set of policies to revitalize primary care, representing either new departures or renewed emphases. It is very important that we obtain input from physicians, the Congress and others on the key elements of such a package and we intend to do so.

For CY 1993 we are recommending separate updates for surgical services and nonsurgical services based on the default update mechanism. That is, we are recommending that the physician fee schedule update be established separately for these two categories of physician services. Each update would equal the MEI plus or minus the number of percentage points that the increase in expenditures varied from the performance standard rate of increase for FY 1991.

The performance standard rate of increase for FY 1991 was 3.3 percent for surgical services and 8.6 percent for nonsurgical services. Expenditures between FY 1990 and FY 1991 increased by 2.9 percent for surgical services (or 0.4 percentage points less

than the performance standard for surgical services) and 10.5 percent for nonsurgical services (or 1.9 percentage points more than the performance standard for nonsurgical services). Therefore, for the CY 1993 update, we recommend an update of 2.6 percent for surgical services (2.2 percent plus 0.4 percentage points) and 0.3 percent for nonsurgical services (2.2 percent minus 1.9 percentage points). (See Table on page 9.) As discussed, above, our update recommendation may need to be adjusted for any changes in our estimate of the MEI.

Section 1848(d)(2)(D) of the Act requires the Secretary to recommend an update for each "category of physicians' services...and for each of the following groups of physicians' services: nonsurgical services, visits, consultations, and emergency room services." We are recommending separate updates only for surgical and nonsurgical services. Nonsurgical services are essentially all services other than those we categorized as surgery. We believe it would be inappropriate to have a separate update for any of the groups of services, i.e. visits, consultations and emergency room services, since there was no separate performance standard rate of increase for these sub-categories of nonsurgical services. Rather, these services are included in the overall nonsurgical services standard. Providing a separate update (higher or lower) for these or any other groups of services should be done, in our judgement, only if separate performance standards existed for the groups of services or where a higher or lower update is justified by other considerations such as evidence of inappropriate utilization, access problems, etc.

As we have stated in our performance standard recommendation, the statute requires that the update for surgical services be applied on a procedure-specific basis without regard to physician specialty. On May 3, 1990, we defined surgical services in the Federal Register for the purposes of the MVPS to include surgical services that are performed by surgical specialists and stated our intention to define surgical services on a procedure-specific basis. For the purposes of the FY 1993 volume performance standard and CY 1993 fee schedule update, in general, we expect to consider a procedure to be surgical if:

- The service is performed by surgical specialists more than 50 percent of the time; and
- The service is classified as "type of service" surgery.

We believe this procedure code definition is consistent with the general definition of surgical services published in the May 3, 1990, Federal Register.

The "surgical" services defined as surgery for coding purposes (i.e. the American Medical Association's Current Procedural Terminology or the internal HCFA type of service classification system) which we expect will be excluded from this definition are diagnostic endoscopic procedures performed mostly by gastroenterologists and other internal medicine specialties, cardiac catheterizations (which are primarily performed by cardiologists), and some minor surgeries performed primarily by internists and general practitioners. We expect to include the specific listing of surgical services in a Federal Register notice to be published announcing the FY 1993 MVPS and CY 1993 physician fee schedule update by October 31, 1992.

Secretary's Recommended 1993 Update

		Surgery	Non-Surgery
(1)	CY 1993 MEI*	2.2%	2.2%
(2)	Difference Between Performance & MVPS	0.4%	-1.9%
(3)	Recommended Update	2.6%	0.3%

*Current estimate, subject to change.

Medicare Volume Performance Standards Recommendation for Fiscal Year 1993

Background

Section 6102 of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239) added section 1848, Payment for Physicians' Services, to the Social Security Act (the Act). Section 1848(f) of the Act establishes the Medicare volume performance standard (MVPS), which is a system for establishing goals for the rate of growth in expenditures for physicians' services. The MVPS rates of increase are not limits on expenditures. Payments for services will not be withheld if performance rates of increase are exceeded. Rather, the success or failure in meeting the performance standard would be one of the factors considered in setting the annual fee update in a subsequent year.

The Secretary of Health and Human Services is required to recommend to Congress by April 15 of each year the performance standard rates of increase for the fiscal year beginning in that calendar year. The MVPS recommendation being made in this report is for Fiscal Year (FY) 1993, i.e., the year beginning October 1, 1992, and ending September 30, 1993. In making the recommendation the Secretary is required to consider:

- Inflation.
- Changes in the number of enrollees.
- Aging of enrollees.
- Changes in technology.
- Evidence of lack of access to physicians' services.
- Evidence of inappropriate utilization of services.
- Other factors that the Secretary considers appropriate.

The Physician Payment Review Commission (PPRC) is required to review the Secretary's recommendation and make its own recommendation to Congress by May 15. If Congress does not establish an MVPS for a fiscal year by October 31, the MVPS rates of increase will be established through an automatic default mechanism as set forth in Section 1848(f)(2)(A) of the Act. Under this mechanism, the MVPS rates of increase would equal the product of the following factors, less an adjustment described below:

- The estimate of the weighted average percentage increase in physicians' fees for calendar years included in the fiscal year involved.

- The estimate of the percentage increase or decrease in the average number of enrollees (excluding risk HMO enrollees) from the previous fiscal year to the fiscal year involved.

- o The Secretary's estimate of the average annual percentage growth in volume and intensity of physicians' services for the 5-fiscal year period ending with the preceding fiscal year.

- o The Secretary's estimate of the percentage increase or decrease in expenditures for physicians' services resulting from changes in law or regulations.

This product is then reduced by a performance standard adjustment factor set by statute. This factor is 2.0 percentage points for all fiscal years after 1992. The table below shows the performance standard rates of increase established for FY 1990, FY 1991 and FY 1992.

Performance Standard Rates of Increase for Prior Years
(Expressed as Percentages)

	All Services	Surgery	Nonsurgery
FY 1990*	9.1	-	-
FY 1991**	7.3	3.3	8.6
FY 1992***	10.0	6.5	11.2

* The performance standard rate of increase for FY 1990 was 9.1 percent for all physicians' services and was computed in accordance with Section 1848(f)(1)(D) of the Act, which did not require separate performance standards for surgical and nonsurgical services. Beginning with FY 1991, we are required to establish separate performance standards for surgical and nonsurgical services.

** In November 1990, Congress specified in OBRA 1990 the methodology for determining the FY 1991 MVPS only. The 5.3 percentage point difference between surgical and nonsurgical procedures is largely due to OBRA 1990 provisions which had the effect of reducing payments for surgical services and expanding benefits or increasing payments for certain nonsurgical services.

*** The FY 1992 MVPS was calculated using the automatic default mechanism specified in Section 1848(f)(2)(A) of the Act.

Definition of Surgical Services

We announced our definition of surgical services for MVPS purposes in the Federal Register on May 3, 1990. Surgical services are defined as follows:

- All services classified as type of service "surgery" in the Medicare payment record that are performed by specified surgical specialists.

- All services currently classified as type of service "assistant at surgery" in the Medicare payment record.

We are using this definition to measure annual growth in expenditures for surgical and nonsurgical services relative to the FY 1991 performance standard rates of increase. Our definition is being used to estimate expenditure growth relative to each performance standard and not to classify individual services as surgical or nonsurgical. However, in our notice on May 3, 1990, defining surgical services, we stated that any differential in the annual update because of separate performance standards would be applied on a procedure-specific basis without regard to specialty.

As indicated in our update recommendation, we are currently in the process of classifying specific procedure codes as either surgical or nonsurgical for the purposes of determining the separate payment updates for surgical and nonsurgical services for calendar year 1993. This procedure specific definition will also be used to determine performance standards for surgical and nonsurgical services for FY 1993.

Categories of Services Subject to Separate Performance Standards

For FY 1993, we are recommending separate performance standards for surgical services and other services, consistent with the requirements of current law.

Inflation

Our estimate of this factor is based on the Medicare Economic Index (MEI). We are continuing to use the MEI as a primary measure of inflation because it is a statutorily mandated measurement of allowable increases in payments for physicians' services under the Medicare physician fee schedule. Our most recent estimate of the MEI for CY 1993 is 2.2 percent. We expect that our current MEI estimate might change between now and when the FY 1993 MVPS is enacted because of more recent economic data and use of a new methodology for computing the MEI which will finalize a proposed policy published in the Federal Register on September 9, 1991.

Similar to our recommendation last year, we are considering two other factors which will have an effect on the general level of physicians' fees in FY 1993:

- Laboratory services, which are included in the MVPS definition of physicians' services, received a statutory update of 2.0 percent for 1992 and 1993.

- Nonparticipating physicians are paid 5 percent less for their services than participating physicians. Participation rates have climbed steadily each year and we assume that this trend will continue.

When all of these factors are considered, the weighted composite inflationary effect on physicians' fees is estimated to be 2.6 percent for surgical services, and 2.7 percent for other physician services. This number is based on the most current projections now available. Changes in the economic projections and the MEI methodology between now and October--when the MEI update is usually calculated--may affect this figure.

Enrollment

Average Medicare Part B enrollment in FY 1993 is estimated to be 34.175 million. Decreasing that figure by estimated enrollment in risk health maintenance organizations (HMOs) of 1.578 million results in a net figure of 32.597 million Part B enrollees, excluding risk HMO enrollees, in FY 1993. The corresponding figures for FY 1992 are 33.552 million, 1.421 million, and 32.131 million, respectively. This yields an increase exclusive of risk HMO enrollees of 466,000 beneficiaries, or 1.4 percent, for surgical and all other physician services.

Aging

We are estimating that the age of the average Medicare beneficiary will increase contributing to slightly expenditures for Medicare services. Aging of the Medicare population would add 0.1 percentage points to the performance standards for surgical and all other physician services in FY 1993.

Technology

As we stated in last year's MVPS recommendation, we do not expect to be able to quantify the effects of technology on expenditure growth in the near future. While improvements in our data systems will be helpful for tracking year to year increases in expenditures for specific procedures, we do not believe it will be possible to isolate the effects of technology because rates of growth can be attributed to many factors. However, we plan to continue to study this issue to improve our understanding of how technological innovation affects Medicare spending.

Inappropriate Utilization

For our FY 1991 MVPS recommendation, we reviewed studies of inappropriate utilization of specific procedures and the extent of geographic variation in utilization. Based on these studies, we remain concerned about the extent of inappropriate utilization. However, we cannot quantify its effects based on limited data and continue to believe that the extent of inappropriate utilization cannot be quantified for our MVPS recommendation. We also expressed our concern about upcoding (billing for a service at a higher level than what was rendered) and unbundling (billing for additional services which were previously included in a single bill).

As required by section 1848(g)(7) of the Act, our annual report on access and utilization discusses the Department's long term strategy for addressing these issues. Furthermore, the Agency for Health Care Policy and Research (AHCPR), Public Health Service, is continuing to assess the appropriateness and effectiveness of particular Medicare services to assist in improving medical practice. We expect our annual report on access and inappropriate utilization and the work of AHCPR to be of key assistance in the future. In future years, we expect these efforts to provide useful information for quantifying the effects of inappropriate utilization.

Access

As stated in last year's MVPS recommendation, we expect a national survey of current Medicare beneficiaries (CBS) which began in September, 1991 to provide useful information on access to services. Furthermore, we also address issues of lack of access through our annual report to Congress on access and utilization.

We would also note that policies already exist to improve beneficiary access to services. The participating physician program gives physicians incentives to accept the Medicare allowance as payment in full. Participation rates have increased in every year since the inception of the program. Additionally, physicians providing services to Medicare beneficiaries in health professional shortage areas (HPSAs) can receive a bonus of 10 percent of the Medicare allowance. Congress has also established a variety of other health professional resource programs (such as the National Health Service Corps) which give physicians incentives to practice in medically underserved areas.

Our report on utilization and access indicates how we will continue to monitor beneficiary access to services as the physician fee schedule is implemented. However, we have no information to indicate that a specific factor for access should be included in this year's MVPS.

Other Factors

In our FY 1993 recommendation, we are considering three other factors in addition to the factors specified in the statute: (1) the FY 1993 impact of the transition to the fully implemented physician fee schedule on January 1, 1996, (2) the FY 1993 impact of the physician fee schedule update for CY 1993 that would be established through the default mechanism, and (3) the FY 1993 impact of legislative changes enacted in OBRA 1990.

Transition to the fully implemented physician fee schedule will have a differential effect on the performance standard for surgical and nonsurgical services. As implementation of the physician fee schedule will have the effect of reducing the payment amounts for most surgical services, the performance standard for surgical services will be reduced due to this factor.

Payments under the physician fee schedule will increase for many nonsurgical services (i.e., office visits and consultations) and decrease for many other nonsurgical services (i.e., radiology, pathology, and other procedural oriented nonsurgical services). These factors will result in a net increase in the performance standard for nonsurgical services.

Our recommendation assumes that the physician fee schedule update will be established through the automatic default mechanism, which is also explained in our CY 1993 physician fee schedule update recommendation. Under the default mechanism, the update for CY 1993 is equal to the MEI increased or decreased by the number of percentage points that the percentage increase in expenditures between FY 1990 and FY 1991 exceeded or was less than the performance standard for FY 1991. Expenditures for nonsurgical services increased by 1.9 percentage points more than the FY 1991 performance standard while expenditures for surgical services increased by 0.4 percentage points less than the performance standard for FY 1991. Because the default update will result in a higher update for surgical services than other services, this factor will have the effect of increasing the performance standard for surgical services and decreasing it for other services.

The FY 1993 effect of OBRA 1990 will result in aggregate decreases for both surgical and nonsurgical services due to payment limits for new physicians. Payment limits for new physicians will affect the performance standards for both surgical and nonsurgical services. Also, the elimination of payment for electrocardiogram interpretations performed or ordered in conjunction with a visit or consult will have the

effect of reducing the performance standard for surgical and nonsurgical services in FY 1993. The elimination of separate payment for electrocardiograms primarily affects the performance standard for nonsurgical services.

The net effect of these three provisions on the performance standard rates of increase are -1.9 percentage points for surgical services, -0.2 percentage points for nonsurgical services and -0.7 percentage points for all physician services.

Recommendation

Our MVPS recommendation for FY 1993 is consistent with the structure of present law, which calls for separate treatment of surgical and nonsurgical services. However, for FY 1994 and subsequent years we will consider alternative approaches, particularly those which could help to address the need for primary care. This is discussed more fully in our report on the 1993 physician fee update recommendation (see pages 6-7 of the CY 1993 Physician Fee Schedule Update Report).

The MVPS system was established by Congress to set goals to encourage the physician community to moderate increases in volume and intensity for physicians' services under the Medicare program. Accordingly, the MVPS should define an acceptable rate of expenditure growth. Performance is assessed by comparing actual growth with the MVPS standard.

As we have stated in prior years, to set clear incentives for physicians, it is important to distinguish between (a) changes in outlays resulting from changes in volume and intensity, and (b) changes in outlays resulting from changes in law or regulation affecting Medicare benefits or the prices paid for services. Physicians should be held accountable for their own actions, not for program changes enacted by Congress. Therefore, the MVPS should be increased to account for legislative provisions which have the effect of increasing Medicare expenditures. If the MVPS is not adjusted to account for legislation which increases the rate of growth in expenditures, even if physicians lowered the rate of increase in the volume and intensity of services, they still could not meet the performance standard. Similarly, the MVPS should be decreased to account for legislative changes which reduce expenditures for physicians' services. If the MVPS is not adjusted to account for legislation which decreases the rate of growth in expenditures, physicians would have inappropriate incentives to increase the volume and intensity of services.

The effects of inflation, enrollment, aging, legislative provisions and implementation of the fee schedule are estimated to have a total effect in FY 1993 of 2.2 percentage points for surgical services and 4.0 percent for other services. We

recommend adding an additional 3.7 percentage points to the performance standard for surgical and other services to account for growth in the volume and intensity of services. This is the same factor we recommended for the FY 1991 and FY 1992 MVPS. The 3.7 percentage point figure was derived by taking one-half of the 7.4 percent average growth in the volume and intensity of services for the five year period ending with the fiscal year in which physician payment reform was enacted by OBRA 1989. We believe 3.7 percent is an adequate allowance for volume and intensity because it approximates the growth in physician services for the under 65 population and it is also greater than the projected growth in real GNP for FY 1993. We believe this allowance provides for a reasonable rate of growth above that attributable to inflation, enrollment, and aging. We will continue to evaluate this allowance as further data becomes available.

Combining all these factors and taking into account interactive effects, our overall recommendation for the FY 1993 performance standard rates of increase is 6.0 percent for surgical services and 7.9 percent for other services (7.3 percent for all services). (See Table on page 9.)

Estimate of Factors Affecting FY 1993 MVPS
(Expressed as Percentages)

	Surgery	Nonsurgery	All Services
Inflation	2.6	2.7	2.7
Enrollment	1.4	1.4	1.4
Aging	0.1	0.1	0.1
Factors Other Than Inflation, Enrollment and Aging	3.7	3.7	3.7
Legislation	-1.9	-0.2	-0.7
Total	6.0	7.9	7.3

Note: Our recommendation should be adjusted to account for changes in pricing and benefits resulting from legislation enacted this year, if any, affecting FY 1993 Medicare physician outlays. Additionally, our recommendation should also be adjusted to reflect any changes in our estimate of the MEI for 1993.

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